Washington State Health Care Authority
Public Employees Benefits Board

C

Medicare Advantage Plan Election Form

Please fill in all information requested. Be sure to read the back of this form.

Retiree/Spouse Information

Social Security Number	Last Name (as appears on Medicare card) First Name Middle Initial	Home Phone
Permanent Residential Address	❑ Male ❑ Female / Date of Birth (Mo/Day/Yr)	❑ Married (Mo/Day/Yr)
City / State / ZIP Code +4	County (Residence)	Medical/Dental Effective Date (Mo/Day/Yr) / /
Mailing Address (if different from above)	City / State	ZIP Code +4

Relationship **SPOUSE**	Last Name First Name Middle Initial	Social Security Number	Date of Birth (Mo/Day/Yr)
Permanent Residential or Mailing Address (if different from above)	City / State		ZIP Code +4

Medicare

Retiree

Retiree Name _____

Medicare Claim Number_____-_____-_____-_____

Is entitled to: Effective Date

Hospital (Part A) _____ _____ _____

Medical (Part B) _____ _____ _____

Spouse

Spouse Name _____

Medicare Claim Number_____-_____-_____-_____

Is entitled to: Effective Date

Hospital (Part A) _____ _____ _____

Medical (Part B) _____ _____ _____

PCP and Plan Choice

I wish to enroll in:

Group Health Cooperative

❑ Group Health Medicare Advantage

Kaiser Foundation Health Plan of the Northwest

❑ Kaiser Permanente Senior Advantage

I wish to cancel my current medical coverage: ❑ Yes ❑ No

I wish to enroll in:

❑ DeltaCare, administered by Washington Dental Service
Dentist name or clinic code

❑ Willamette Dental of Washington, Inc.
Clinic location

❑ Uniform Dental Plan, administered by Washington Dental Service

Retiree

Name of Contracting Primary Care Physician (PCP) (refer to Plan's Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Spouse

Name of Contracting Primary Care Physician (refer to Plan's Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Medical Information

1. **Do you currently have end-stage renal disease (kidney disease)?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
2. **Do you have any health insurance other than Medicare?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, through which company?_____
   What type of policy?_____
   Do you intend to discontinue this policy?
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Note: Your answers to questions #3 and #4 below will **not** affect your eligibility to enroll in a Medicare Advantage plan.

3. **Do you live in an institution?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, name of institution _____
   Address _____
   Phone number _____
   Date of admission _____
4. **Are you currently receiving Medicaid?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, Medicaid #: _____

Signature and Authorization continued on back

Signature and Authorization

I authorize Department of Retirement Systems to deduct from my retirement allowance the amount required to pay for this coverage.
❑ Yes, deduct from my pension ❑ No, I will send my payment monthly

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we qualified. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

We have read and understand this form, including the Statement of Understanding below. We know that we must refer to our plan's Certificate of Coverage for rules we must follow to receive coverage under this Medicare Advantage contract.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with DRS to better serve you.

This form cannot be signed more than 90 days before the effective date of this coverage.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To receive our Privacy Notice, call 360-725-0442 or go to www.hca.wa.gov.

Signature of Applicant _____ Date _____ Signature of Spouse _____ Date _____

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where he or she resides) on this application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from the Medicare Advantage Plan or by Medicare.

Signature of individual who assisted the applicant and/or spouse in completing this form _____ Date _____

If you are the authorized representative, you must sign above and provide the following information:

Name _____ Relationship to applicant _____

Address _____ Phone _____

STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare Advantage plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare Advantage plan will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage plan will release my information to Medicare, which may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage coordinated care plan at any time. By enrolling in the Medicare Advantage plan I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare Advantage coordinated care plan of which I may be a member.

By enrolling in the Medicare Advantage plan, I authorize the CMS to provide information to the Medicare Advantage plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare Advantage plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage plan I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage plan by sending a written request to the Medicare Advantage plan I have selected, and the PEBB Program, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage plan providers.

I understand that as a member of the Medicare Advantage plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage plan I have selected is effective the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during PEBB's annual open enrollment, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the Medicare Advantage plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage plan identification card. Until you receive your Medicare Advantage identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

2013 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233 • 1-888-901-4636 or TTY 1-800-833-6388
Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-877-221-8221 or TTY 1-800-735-2900

2013 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 • 1-800-650-1583
Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157 • 1-800-537-3406
Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611 • 1-855-433-6825

Please return this form by mail to:
Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684 ***or fax to:*** 360-725-0771